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JANUARY 1980

	Aseptic Meningitis	Chickenpox	Encephalitis - tota	Giardia	Gonorrhea	Hepatitis Infectious	Hepatitis Serum	Influenza	Measles	Meningococcal Disease	Mumps	Pertussis	Rabies in Animals	Rubella	Salmonella	Shigella	Strep Infections	Tuberculosis
Beaverhead					1													
Big Horn					4	13											41	
Blaine					5												24	
Broadwater																		
Carbon																	6	
Carter																		
Cascade	1	79			6	3		13			1				2	1	6	
Choteau								20										
Custer		12			3												12	
Daniels																		
Dawson																	4	
Deer Lodge					1			56									31	
Fallon																		
Fergus					1													
Flathead		3			5			100			14						1	
Gallatin		3			2	2											86	
Garfield																		
Glacier		4		1	11	3										1	41	1
Golden Valley																		
Granite																		
Hill		2		1	2										1	1	27	
Jefferson																		1
Judith Basin																		
Lake				1	2		1											
Lewis & Clark		53			5					1							4	
Liberty																		
Lincoln		1																
McCone																		
Madison																		
Meagher																		
Mineral					2													
Missoula		2			16										3		1	
Musselshell																		
Park																		
Petroleum																		
Phillips																		
Pondera						2		15									1	
Powder River																		
Powell				1														
Prairie																		
Ravalli		1						100									3	
Richland					1		1											
Roosevelt					2											1		
Rosebud					2						1					4	5	
Sanders		9						10									9	
Sheridan													1					
Silver Bow					12	1		16							1			1
Stillwater								5									2	
Sweet Grass						1												
Teton					1													
Toole																		
Treasure																		
Valley					1												2	
Wheatland																		
Wibaux																		
Yellowstone					18	2												
TOTAL THIS MONTH	1	169	0	4	103	27	2	335	0	1	16	0	1	0	7	8	306	3
19																		
19	0	220	0	2	152	15	0	754	12	2	2	1	0	6	3	5	674	3
19	1	152	0	N/A	174	30	0	567	2	0	4	0	0	0	4	2	515	1
REPORTED TO DATE																		
19																		
19																		
19																		

Other Reportable Diseases: 1 Hepatitis, Unspec. - Cascade
1 Typhoid Fever - Missoula
1 Reyes Syndrome - Cascade
6 Mononucleosis - 2 Gallatin, 1 Missoula, 3 Stillwater

Delayed Reports (1979): 1 Aseptic Meningitis - Missoula, 2 Hepatitis B - 1 Cascade (Deduct 1 Hep.A) 1 Lewis & Clark; 1 Meng. Disease - Flathead, 2 Pertussis - Big Horn; 2 Rubella - Missoula, 1 Salmonella - Missoula.

GUIDELINES FOR CARE OF PATIENTS HOSPITALIZED WITH HEPATITIS

The Center for Disease Control has published new guidelines[1] for hospital care of patients with viral hepatitis. These guidelines provide us with a formal statement which summarizes data and liberalized isolation procedures.

DIFFERENTIATING BETWEEN HEPATITIS A AND HEPATITIS B

Both hepatitis A and hepatitis B damage the liver; and both are cuased by viruses. However, their similarity ends here. They are clinically and epidemiologically distinct. The prodrome, some of the signs and symptoms, the course, the prognosis, the incubation period, the mode of transmission, and the methods for prevention are very different.

Hepatitis A virus (HAV) is acquired by fecal-oral transmission. "HAV does not produce a viremia which is extensive enough to be a concern for the transmission of virus through direct contact with blood."[1] Large amounts of virus are excreted in the stool especially during the late incubation perod and the prodrome (i.e. for about 1 to 2 weeks preceeding the onset of jaundice). HAV excretion falls off dramatically with the onset of signs of hepatic injury. By the time the patient is jaundiced, which is often when he seeks medical advice, the HAV load in the stool is very low. It is the current belief that the period of communicability coincides with the period of maximum virus excretion and that, once jaundice is present, the patient is not very communicable. (NOTE: there are reports of nosocomially acquired hepatitis A, which the reference article discusses in some detail.)

Hepatitis B virus (HBV) is acquired by exposure to blood and certain body fluids. There is general agreement that a fecal-oral route of HBV transmission does not exist. The efficiency of HBV transmission is almost solely related to the amount of circulating virus in the blood of infected persons who "are in the acute phase of infection or are chronic HB_sAg carriers and positive for hepatitis B e antigen (HB_eAg)". [1]

DIAGNOSIS: Hepatitis B is diagnosed by finding the viral antigen in serum. This is reported as a positive HAA (or HB_sAg) test. Hepatitis A can be diagnosed when the antibody to the virus is present in serum. This is the anti-HAV test. Unless the IgM fractionation is done and has anti-HAV, one cannot be sure that the antibody represents recent infection.

When there is no serological evidence for HBV or HAV infection, by definition this is non-A, non-B hepatitis, which is epidemiologically similar to hepatitis B. When no tests for hepatitis A or hepatitis B are done, the illness should be classified as hepatitis unspecified.

RECOMMENDATIONS: According to this article, and we agree, elaborate isolation procedures for hospitalized patients with viral hepatitis are not necessary. An underlying assumption for the new recommendations is that the communicability of hepatitis A is directly proportional to the quantity of virus shed in the stool, and that low numbers have a low (not necessarily zero) level of infectiousness. Blood precautions, a standard procedure of good medical practice, should be emphasized for patients with all types of viral hepatitis. Because human nature is fallible, many hospitals may want to continue to post enteric precautions for hepatitis A.

When the enteric precaution sign is used, a private room would be needed only for gross fecal incontinence; gowns would not be necessary except for cleaning up gross fecal contamination; gloves would be advised only for handling articles contaminated with feces; and articles contaminated with feces should be wiped clean with a detergent and then wiped with a disinfectant. Handwashing upon entering and leaving the room is a must.

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(1) Favero MS, et.al. "Guidelines for the Care of Patients Hospitalized with Viral Hepatitis". Ann Int Med 91:872-876 (1979)

REPRINTED (edited) FROM THE OREGON COMMUNICABLE DISEASE SUMMARY, VOL. 29-4

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MAY 1980

	Aseptic Meningitis	Chickenpox	Encephalitis total	Giardia	Gonorrhea	Hepatitis Infectious	Hepatitis Serum	Influenza	Measles	Meningococcal Disease	Mumps	Pertussis	Rabies in Animals	Rubella	Salmonella	Shigella	Strep Infections	Tuberculosis
Beaverhead																		
Big Horn		12	1		2												49	
Plaine		1			1	2											31	
Broadwater																		
Carbon					1													
Carter																		
Cascade		70			18										2			
Choteau								26									3	
Custer					4												21	
Daniels																		
Dawson					2		1										14	
Deer Lodge					1			4									10	
Fallon																		
Fergus					2													
Flathead		2			9													
Gallatin	1	7			8											1	37	
Garfield																		
Glacier					3	3											11	
Golden Valley																		
Granite																		
Hill		26		1		2		4							1		29	
Jefferson																		
Judith Basin																		
Lake		1								1							3	
Lewis & Clark		5		2	3										1		2	
Liberty																		
Lincoln					1						1							
McCone																		
Madison																		
Meagher																		
Mineral																		
Missoula					12									12				
Musselshell																		
Park																		
Petroleum																		
Phillips																		
Pondera								8									1	
Powder River																		
Powell																	9	
Prairie																		
Ravalli		3		1													2	
Richland					2													
Roosevelt					1													
Rosebud					4												8	
Sanders				1													50	
Sheridan		2																
Silver Bow					1													
Stillwater																		
Sweet Grass																		
Teton																		
Toole																		
Treasure																		
Valley					5													
Wheatland																		
Wibaux																		
Yellowstone	1		1		22						2							
TOTAL THIS MONTH 1980	2	129	2	5	102	7	1	42	0	1	3	0	0	12	4	1	280	0
1979	0	120	0	5	147	12	0	129	6	1	0	1	0	5	3	17	282	2
1978	1	25	0	NA	137	3	0	44	16	0	2	1	0	3	2	22	124	3
REPORTED TO DATE 1980	4	852	5	20	573	85	11	4127	1	2	48	1	9	29	25	13	2209	11
1979	2	688	2	23	817	82	8	1552	53	4	5	10	0	55	28	69	2075	13
1978	2	545	1	NA	876	128	11	2163	94	2	9	6	2	11	17	38	2111	22

Other Reportable Diseases:
4 Colorado Tick Fever - 1 Fergus, 3 Ravalli
2 Hepatitis Unspec. - 1 Cascade, 1 Glacier
3 Bacterial Meningitis - 1 Gallatin, 2 Lewis & Clark
2 Rocky Mountain Spotted Fever - 1 Cascade, 1 Silver Bow
1 Tularemia - Lake
4 Mononucleosis - 2 Custer, 1 Gallatin, 1 Ravalli

STD TRAINING AVAILABLE IN DENVER

One of eight national facilities offering specialized training in the diagnosis, treatment and prevention of sexually transmitted diseases (STD) is now located in Denver, Colorado. The Denver STD Training Center is a cooperative effort by Denver Health and Hospitals, the Colorado Department of Health and the Center for Disease Control.

The need for effective clinical services has been recognized as essential to the control of STD. Consequently, the Training Center was developed to give participants a concise presentation of current knowledge and recent developments in the care of patients with this complex group of problems.

The Training Center is located within the Denver Public Health Department, and has its own conference room, library and demonstration laboratory. The adjoining Denver Metro Health Clinic, which records over 22,000 STD patient visits each year, is used for clinical training. Franklyn N. Judson, M.D., associate Director of the Denver Public Health Department, directs the Training Center. The faculty is drawn from Dr. Judson's staff, the Colorado Department of Health, the University of Colorado Health Sciences Center, and the University Health Clinic.

Courses offered include:

STD Level I: a 2-week (80 hr.) entry-level course for health care personnel, regardless of job title, involved in the clinical management of patients with STD's. The curriculum includes: STD diagnosis, patient management, patient-clinician interaction, clinic records, history taking, physical exam, laboratory techniques and practical experience with patients.

STD Level II: Participants include graduates of the Level I course after 2-4 months of practical clinical work and experienced personnel desiring advance training. This is a 5-day (40 hr.) course which builds on Level I skills. STD's are explored in depth, emphasizing problem solving, complicated diagnosis and treatment, laboratory problems, clinic management and problem patients.

STD Update for Physicians: This is a 2-day update course for practicing physicians. Topics covered include gonorrhea, syphilis, herpes, non-gonococcal urethritis, chlamydia, warts, mite infections, vaginitis, serology interpretations, laboratory workshops and case problem discussions.

All courses are tuition-free and qualify for both Colorado Nursing Association and AMA Category I continuing education credits. Educational methods include lectures, class discussion and audio-visual presentations. Practical experience in clinical laboratory work is provided in both the STD Level I and II courses.

COURSE SCHEDULES

STD Level I		STD Level II		Physician Update	
July	7-18	August	22-27	August	22-23
August	4-15	November	14-19	November	14-15
September	8-19				
October	20-31				
December	1-12				

For inquiries and applications, contact: The Denver STD Training Center, 605 Bannock St., Denver, CO 80204; (303) 893-7446, FTS 327-5640.

Ref. "Colorado Disease Bulletin", Vol. 8-17, April 26, 1980.

NEW STAFF MEMBER

Judith Gedrose, R.N., M.N., is the new Public Health Nurse Consultant on the Preventive Health Services Bureau staff. This position has been vacant since Char Knaub left for Cambodia last October, and we are very pleased to have it filled again with someone with Judy's training and experience.

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JUNE 1980

	Aseptic Meningitis	Chickenpox	Encephalitis - tot.	Giardia	Gonorrhea	Hepatitis Infectious	Hepatitis Serum	Influenza	Measles	Meningococcal Disease	Mumps	Pertussis	Rabies in Animals	Rubella	Salmonella	Shigella	Strep Infections	Tuberculosis
Beaverhead																		
Big Horn		6			3	3											36	
Blaine		2			4										1	1	36	
Broadwater																		
Carbon																		
Carter																		
Cascade		23			12										1		10	
Choteau								20										
Custer					2												13	
Daniels		1											1					
Dawson																	15	
Deer Lodge					1			14									17	1
Fallon													1					
Fergus					1													
Flathead					5			2			2			1				1
Gallatin		3			1			10			1			2			47	
Garfield																		
Glacier						1											8	1
Golden Valley																		
Granite																		
Hill		38			4												29	
Jefferson																		
Judith Basin																		
Lake					4												23	
Lewis & Clark		13													1			
Liberty																		
Lincoln					1													1
McCone													1					
Madison																		
Meagher																		
Mineral																		
Missoula		1			18									4	9			
Musselshell																		
Park					2													
Petroleum																		
Phillips					1										1			
Pondera		4						7									9	
Powder River																		
Powell																		
Prairie																		
Ravalli		2															2	
Richland													1					
Roosevelt					5												1	1
Rosebud					9													
Sanders																		
Sheridan													1				2	
Silver Bow							1										18	
Stillwater																		
Sweet Grass																		
Teton					1													
Toole													1					
Treasure																		
Valley					1												7	
Wheatland																		
Wibaux																		
Yellowstone					12	2	1									1		
TOTAL THIS MONTH 1980	0	93	0	0	88	6	2	53	0	0	3	0	6	7	13	2	273	5
1979	4	93	0	9	140	10	2	51	1	2	0	0	0	7	2	25	178	3
1978	0	87	0	NA	174	18	2	72	9	0	126	1	0	2	6	12	200	6
REPORTED TO DATE 1980	4	947	5	21	661	96	13	4180	1	2	51	1	23	39	38	15	2638	16
1979	7	781	3	32	949	91	10	1603	55	6	5	11	4	62	30	80	2253	17
1978	2	632	1	NA	1050	146	13	2163	103	2	135	7	2	13	23	50	2311	28

Other Reportable Diseases: 1 Amebiasis - Yellowstone; 1 Bact. Meningitis - Rosebud; 1 Hepatitis, Unspec. - Lake, 1 RMSF - Golden Valley; 3 Tularemia - 1 Big Horn, 1 Valley, 1 Yellowstone.

Delayed Reports: 2 Chickenpox (March); 1 Giardia - Yellowstone; 5 Hepatitis A - 3 Big Horn, 1 Cascade; 1 Hepatitis B - Powell; 8 Rabies in Animals; 156 Strep Inf.; 3 Rubella; 1 Tuberculosis.

HEPATITIS TESTING AND DIAGNOSIS

A case of simultaneous infection with Type A and B hepatitis virus was reported recently through our surveillance program. Investigation of the case, and subsequent cases, has been confounded by several factors. One aspect of facilitating future investigations will be discussed here.

With the discovery of serologic methods for detecting hepatitis A antibodies, more definite diagnoses related to hepatitis have become possible. Certainty in diagnosis depends upon the specificity of laboratory reports. Since the testing for hepatitis A is still relatively new, it is only done in some laboratories; some of which test for anti-HAV only, while others further analyze the specimen relative to IgG and IgM components of the antibodies. The more specific IgG and IgM tests allow the diagnostician to evaluate whether the antibodies have been produced in an acute infection, or whether they are a product of an earlier, possibly undiagnosed hepatitis A infection. The following guidelines can be used:

1. IgM antibodies begin to rise with onset of aminotransferase abnormalities.
2. This is followed by a rise in IgG antibody.
3. IgM antibody disappears in 4 to 5 weeks.
4. IgG antibodies may persist indefinitely. 1/

While hepatitis A has a very low mortality rate, it can have significant economic and social effects, requiring time and resources of both the patient and health-care worker. An early definitive diagnosis to determine the hepatitis A antibody status of a suspected case gives direction for management of the patient and his contacts. Soon after the patient profile, including laboratory results, indicates probable A infection, contact investigation is undertaken. Although the general communicability of hepatitis A is less than formerly believed, specific situations warrant prophylactic measures for contacts. This is usually accomplished by administration of Immune Serum Globulin. Since ISG is administered only with A infection, and has its maximum effect if given within two weeks from display of symptoms of the index case, early differentiation of the type of hepatitis of the index case is essential.

On the other hand, hepatitis B infection has a fatality rate that varies from 1 to 12% or more. Chronic liver damage is a sequela in more cases of B infection than A infection. Therefore, early determination of acute hepatitis B will insure aggressive treatment at the time of infection, preventing residual effects. ISG probably gives little protection to contacts of hepatitis B. Control of spread can be accomplished by advising the patient that he harbors the virus in his blood, sputum and semen, and discouraging direct or indirect contact with others who might then be exposed to these body fluids. Male homosexuals and injectable drug users have the greatest risk of hepatitis B. infection.

There are other reasons for determining the type of hepatitis infection manifested by a patient. As mentioned above, the possibility of simultaneous hepatitis A and B infection exists. Although the occurrence of simultaneous infections should remain low in Montana, certain individuals (such as male homosexuals and injectable drug users) would be viewed with a high index of suspicion for concurrent A and B infections.

Secondly, there is more to be learned about the etiology of hepatitis. The introduction of specific tests for hepatitis A antibody and hepatitis B antigen revealed a new classification: non-A, non-B hepatitis. Some patients with clinical symptoms of hepatitis have had negative serological results from both A and B testing. A vigorous attempt to classify each case as accurately as possible will allow collection of data for further investigation.

Financial hardships related to routine multiple testing of hepatitis suspects can be reduced by utilizing the CDC hepatitis laboratory in Phoenix, Arizona. However, CDC will accept only those specimens channeled through state public health laboratories. Send your specimens, with a request form, to: Virology Dept., Montana State Microbiology Laboratory, Cogswell Bldg., Helena, MT 59601.

1/ Hirschman, Shalom. Virologic, Immunologic and Clinical Correlations in Viral Hepatitis in Louis Weinstein and Bernard N. Fields, eds. Seminars in Infectious Disease, Vol. II, pp. 48-56.

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JULY 1980

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Beaverhead					2													
Big Horn		5			6	1											29	
Flaine		1			5												26	
Broadwater					1													
Carbon				8	1													
Carter																		
Cascade		11			22	1					2				1		22	
Choteau								65										
Custer					3													
Daniels													2					
Dawson					2										2		20	
Deer Lodge					2			19									23	
Fallon																		
Fergus																		
Flathead					7													
Gallatin		3		3	12			10									30	
Garfield																		
Glacier					1	4											141	
Golden Valley																		
Granite					1													
Hill		1			5				1								21	
Jefferson																		
Judith Basin																		
Lake					8					1				1			13	
Lewis & Clark		4		1	6													
Liberty																		
Lincoln					1													
McCone																		
Madison													1					
Meagher																		
Mineral					2													
Missoula					12									1	72	1		
Musselshell					1													
Park				1	1													
Petroleum																		
Phillips					2													
Pondera		3						13							1		8	
Powder River																		
Powell				1											1		10	
Prairie																		
Ravalli				1											2		1	
Richland					1													
Roosevelt					6													
Rosebud					2										1	3	2	
Sanders																		
Sheridan																		
Silver Bow					3										1			
Stillwater					1													
Sweet Grass																		
Teton																		
Toole																		
Treasure																		
Valley					1								3				10	1
Wheatland																		
Wibaux																		
Yellowstone				1	32	2									2	1		
TOTAL THIS MONTH 1980	-	28	-	16	149	8	-	107	1	1	2	-	6	2	83	5	156	1
1979	2	65	-	2	162	11	2	70	1	1	-	1	1	4	9	19	265	-
1978	-	50	-	NA	173	8	2	21	-	-	1	2	2	4	6	2	203	1
REPORTED TO DATE 1980	4	975	4	39	810	105	13	4287	2	3	53	1	29	42	122	20	3004	18
1979	7	846	3	36	1114	100	12	1675	57	6	10	11	5	65	34	101	2518	22
1978	2	682	1	NA	1223	154	15	2256	103	2	136	9	4	17	29	52	2514	29

Other Reportable Diseases: 2 Colorado Tick Fever - Ravalli; 1 Hepatitis Unspec. - Glacier.

Delayed Reports: 3 Giardia - 1 Granite (March), 1 Gallatin (June), 1 Yellowstone (June)
1 Hepatitis A - Yellowstone (June); 1 Hepatitis Unspec. - Powell (May)
1 Rubella - Lake (May) 1 Salmonella - Missoula (June) 10 Strep. - Valley

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GIARDIA OUTBREAK IN RED LODGE

James Kane, M.D., Carbon County Health Officer, contacted this bureau July 14 to report that he and his colleagues in the Red Lodge Clinic had seen an increased number of patients with diahrreal illness during the first weeks of the month. Treatment with anti-diahrreal drugs and antibiotics was effecting a low level of relief for these patients. Kane reported that elderly patients seemed to be seeking care for this illness and its effects at a higher rate than younger persons. Prostration and dehydration led to the hospitalization of several patients.

A preliminary epidemiological investigation indicated that the main symptoms in a profile for cases were: diahrrea, flatulence, borborygimus; and, in many cases, nausea and vomiting. There were also cases in other areas of Montana reporting a recent association with Red Lodge. It was believed that a substantial number of persons were ill, but had not sought medical advice.

The isolation of giardia lamblia from a stool specimen of a patient prompted physicians to begin treating with anti-protozoal drugs. Patients reported a dramatic relief from symptoms after this treatment.

The preliminary investigation pointed to a common source outbreak of large magnitude. Therefore, the national Center for Disease Control was asked to participate in a full-scale investigation. Two E.I.S. officers and one environmental engineer from EPA arrived in Red Lodge to assist the local and state personnel. With their coordination, and the cooperation of many local residents, the study (not yet completed) was conducted.

Preliminary reports indicate that the Red Lodge Municipal water system was probably the source for giardia lamblia infestation of over 200 persons during the months of June, July and August. The west fork of Rock Creek is the source of the municipal system. Routine water sampling procedures had been carried out, and samples for the past two years were acceptable. Chlorination of the water had been taking place.

This outbreak emphasizes the possibility of other surface water-fed municipal systems in Montana being invaded by giardia lamblia. Chlorination at the usual concentration does NOT eliminate this possibility.

To establish an accurate assessment of the effects of the Red Lodge situation, and possibly help prevent similar occurrences elsewhere, we encourage you to report any confirmed or suspected giardiasis to our office.

A comprehensive report of this outbreak will be published in the future.

SWIMMERS' ITCH

Flathead County Health Officer Bruce C. McIntyre, M.D., reported nine cases of schistosomiasis (swimmers' itch) this month. Four cases were contracted by persons swimming at the junction of Swan River and Swan Lake; five by swimmers from the east shore of Flathead Lake. Snails, thought to be the cause of transmission, have been recovered from those waters.

CRANKSHAW TO THAILAND

Rick Crankshaw, coordinator of the state immunization program, will be leaving in mid-August for a three-month tour in Thailand. Rick will be working in the refugee centers to ensure immunization of all refugees bound for the United States.

Tom Krantz, former north-central Field Officer, has left to enter a Colorado Theological seminary, and his position has been filled by Dick Paulsen.

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Helena, Montana 59601

AUGUST 1980

	Aseptic Meningitis	Chickenpox	Encephalitis - tot.	Giardia	Gonorrhea	Hepatitis Infectious	Hepatitis Serum	Influenza	Measles	Meningococcal Disease	Mumps	Pertussis	Rabies in Animals	Rubella	Salmonella	Shigella	Strep Infections	Tuberculosis
Beaverhead						1												
Big Horn					7										2		20	
Plaine		1			1								1				29	
Broadwater					1													
Carbon				8														
Carter																		
Cascade	1				30			8			1					1	9	
Choteau								70										
Custer					1													
Daniels													2					
Dawson					1											1		
Deer Lodge								11									12	1
Fallon																		
Fergus					2													
Flathead					9													
Gallatin					4			8								1	32	
Garfield					6	2											43	
Glacier																		
Golden Valley																		
Granite					4						1						20	
Hill																		1
Jefferson																		
Judith Basin																		
Lake	1	1			5	2								1			8	
Lewis & Clark		1		1	7										2		1	
Liberty					1													
Lincoln																		
McCone																		
Madison					2													
Meagher																		
Mineral																		
Missoula	1				19	1		1							4	1		
Musselshell																		
Park					1													
Petroleum																		
Phillips																		
Pondera		2			1			4							1		8	
Powder River																		
Powell																		
Prairie																		
Ravalli					1											1	1	
Richland																		
Roosevelt					8													
Rosebud					19											1	2	
Sanders																		
Sheridan																		
Silver Bow					4	4	1	10									12	
Stillwater																		
Sweet Grass																	3	
Teton					2													
Toole																		
Treasure																		
Valley					1							1					5	
Wheatland																		
Wibaux																		
Yellowstone					24	1									2			
TOTAL THIS MONTH	3	5	-	9	154	11	1	112	-	-	2	1	3	1	11	6	205	2
1980																		
1979	11	22	-	6	186	8	1	70	-	1	-	2	3	4	8	1	161	5
1978	19	18	2	NA	218	12	1	39	-	1	-	1	7	-	-	21	204	9
REPORTED TO DATE																		
1980	9	982	3	49	971	116	14	4399	2	3	55	3	33	41	133	26	1209	20
1979	18	868	3	42	1300	108	13	1745	57	7	10	13	8	69	42	102	2881	27
1978	22	700	4	NA	1438	187	20	2795	106	3	141	10	11	17	30	70	2719	40

Other Reportable Diseases: 1 Bact. Meningitis - Silver Bow; 1 Malaria - Lewis & Clark; 4 Tularemia - 3 Big Horn, 1 Carbon; 1 Toxic Shock Syndrome - Ravalli.

Delayed Reports: 2 Aseptic Meningitis- 1 Powell, 1 Ravalli; 2 Colorado Tick Fever - 1 Beaverhead, 1 Gallatin; 1 Giardia - Granite; 1 Hepatitis Unspec. - Roosevelt; 1 Pertussis - Ravalli; 1 Rabies in Animals - Daniels; 1 Tularemia - Big Horn; 2 Chicken Pox - Lake; 20 Strep. - Valley.

PPNG ALERT

Penicillinase-producing Neisseria Gonorrhoeae, or PPNG, is a strain of gonorrhea that has developed the ability to produce an enzyme (penicillinase). The enzyme has the effect of neutralizing the penicillin used to treat the disease.

The first confirmed case of PPNG in Montana was reported this month. Our sister states and Canadian provinces had reported cases, which we considered a source of potential spread of the disease to Montana. Over a year ago we instituted a PPNG watch, consisting of a re-test of all positive cases of gonorrhea with a test of cure (TOC) culture, done three to seven days after treatment. A positive TOC culture would indicate treatment failure, and the laboratory should then automatically retest by the beta-lactamese method to identify the PPNG strain. We also recommended a re-screen test be done four to six weeks after the treatment. These follow-up tests should reveal reinfections by untreated asymptomatic sex partners.

The one case reported in Montana has been traced to the Far East, and we feel confident there has been no additional infection from this source. However, the probability of other such cases and in-state spread is high.

WE MUST BE ON THE ALERT! It is vitally important that all those who diagnose and treat gonorrhea patients follow up with both the TOC and re-screen cultures in order to identify PPNG in Montana. The state microbiology laboratory routinely does beta-lactamese tests on all positive cultures for gonorrhea they receive, BUT - they only get about 40% of those reported throughout the state.

CURRENT CDC RECOMMENDATIONS FOR TREATMENT OF PPNG:

Early use of effective treatment will minimize the spread of and complications from PPNG infections. CDC is now specifically recommending spectinomycin 2g for the initial treatment of uncomplicated anogenital gonorrhea in patients who have recently returned from countries, such as the Philippines, Singapore, and Thailand, that have areas of high prevalence of PPNG infections. The same dosage is also recommended for (1) the initial treatment of patients with proven PPNG infections, (2) treatment of the sexual partners of these patients, and (3) retreatment of patients who have persistent infections after initial therapy with another antibiotic. Isolates of N. gonorrhoeae obtained from patients treated with spectinomycin should be tested for penicillinase production. All patients treated for gonorrhea should have a post-treatment culture taken 3-7 days after treatment.

There are, as yet, no published studies on the treatment of PPNG-associated salpingitis and PPNG pharyngeal infections. Spectinomycin and cefoxitin appear effective in the treatment of salpingitis caused by PPNG. However, these two drugs may be relatively ineffective for pharyngeal gonococcal infection. The fixed-combination antimicrobial sulfamethoxazole/trimethoprim has been used to treat pharyngitis caused by penicillin-sensitive gonococci, and may be effective for PPNG pharyngitis.

Pending definitive studies, the CDC recommends the following regimens:

FOR SALPINGITIS ASSOCIATED WITH ENDOCERVICAL PPNG INFECTION:
1. Outpatients - spectinomycin 2 g IM daily for 5-10 days.
2. Inpatients - cefoxitin 2 g IM or IV every 8 hours for 5-10 days.

Because experience with treatment of this infection is very limited, hospitalization of patients may be advisable.

FOR PPNG PHARYNGEAL INFECTION:
Sulfamethoxazole/trimethoprim 9 tablets (400 mg sulfamethoxazole/80 mg trimethoprim per tablet) daily for 5 days.*

Reference:
*Morbidity and Mortality Weekly Report, V. 29, No. 32; August 15, 1980.

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PHSB 3010-201 Vol: 4:5 Month of: AUGUST, 1980

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	Aseptic Meningitis	Chickenpox	Encephalitis - tota	Giardia	Gonorrhea	Hepatitis Infectious	Hepatitis Serum	Influenza	Measles	Meningococcal Disease	Mumps	Pertussis	Rabies in Animals	Rubella	Salmonella	Shigella	Strep Infections	Tuberculosis
Beaverhead					1													
Big Horn		4			5												33	
Plaine													1				27	
Broadwater																		
Carbon				3														
Carter																		
Cascade		4			7			24					3		1			
Choteau								80									13	
Custer					1								1					
Daniels																		
Dawson		3											1				3	
Deer Lodge				2	2			21									7	
Fallon																		
Fergus					2										1			
Flathead					3								1					1
Gallatin		1			1			5					2				40	
Garfield																		
Glacier						1												2
Golden Valley																		
Granite																		
Hill				1		1							2				24	1
Jefferson																		
Judith Basin													1					
Lake		2						5									24	1
Lewis & Clark				4	4								1		1			
Liberty		1						2									2	
Lincoln														1				
McCone																		
Madison					2													
Meagher					1													
Mineral																		
Missoula	1	1		4	12			3										
Musselshell																	11	
Park																		
Petroleum																		
Phillips																		
Pondera								5						1			6	
Powder River																		
Powell																		
Prairie																		
Ravalli						1												
Richland		4			1													
Roosevelt																		2
Rosebud					4												2	
Sanders																		
Sheridan																		
Silver Bow					2	3		42									52	
Stillwater																		
Sweet Grass																		
Teton					1													
Toole																		
Treasure																		
Valley																	19	
Wheatland													1					
Wibaux																		
Yellowstone				1	21										1			
TOTAL THIS MONTH																		
1980	1	20	-	15	70*	6	-	187	-	-	-	-	14	2	4	-	263	7
1979	3	44	-	8	202	12	-	90	-	4	-	1	-	-	8	6	299	-
1978	3	5	5	NA	178	12	5	118	-	-	-	1	1	1	1	27	151	1
REPORTED TO DATE																		
1980	10	1003	5	111	1041*	123	14	4586	2	3	55	3	47	45	137	26	3472	28
1979	28	911	4	51	1540	118	12	1835	53	16	10	13	5	65	56	111	2980	23
1978	25	705	9	NA	1616	199	25	2413	106	3	141	11	12	18	31	103	2870	41

Other Reportable Diseases: 1 Bacterial Meningitis - Gallatin; 2 Tularemia - Big Horn

Delayed Reports: 1 Aseptic Meningitis - Silver Bow; 1 Chickenpox - Lewis & Clark; 1 Encephalitis - Yellowstone; 47 Giardia - 2 Hill, 4 Liberty, 41 Missoula; 1 Hepatitis A - Cascade; 1 Tuberculosis - Granite.

*Partial data available.

REPORTING DISEASES

The Administrative Rules of Montana related to Public Health have been revised, and reportable diseases have been regrouped into four classifications, delineated by length of time from diagnosis to report of the case. In brief, the classifications are:

Class A Diseases - to be reported within 6 hours.
Class B Diseases - to be reported within 24 hours.
Class C Diseases - to be reported by number, for epidemics only.
Class D Diseases - to be reported within 24 hours after positive diagnosis.

You will be receiving a packet containing:

1. A placard listing reportable diseases by classification to display for ready reference.
2. An updated version of the Communicable and Other Reportable Disease handbook.
3. New cards for reporting epidemics of the following Class C diseases:

Chickenpox	Pediculosis (lice)
Gastroenteritis	Scabies
Kerato-conjunctivitis	Strep. infections (including Scarlet Fever)
Food-borne	Non-polio enteroviral infections (suspected)
Influenza	Swimmer's Itch
Nosocomial	Water-borne

Continue using the yellow Confidential Case Card to report all other diseases, since they require more detailed information.

If you have any questions about reporting diseases, call Judy Gedrose at 449-2645.

UPDATE ON TUBERCULOSIS CHEMOTHERAPY

Chemotherapy for tuberculosis is a two-phase process, the first aimed at rapidly reducing the number of tubercle bacilli in the body, the second at maintaining treatment long enough to eliminate the smaller number of persisting organisms. The striking thing about modern tuberculosis chemotherapy is the flexibility you have in tailoring the treatment to each patient's needs. A vaiety of effective drug combinations and schedules have been developed.

Treatment usually consists of a combination of at least two drugs from the first-line of recommended drugs (Isoniazid (INH), Ethambutol, Rifampin and Streptomycin). The use of two or more drugs in combination increases the terapeutic efficacy and makes the emergence of drug-resistant mutants unlikely.

When a patient's bacterial population is particularly large, three drugs may be used during the early phase of therapy. A large bacterial population is suggested by wide-spread disease, extensive infiltrates and/or cavitary lesions on chest x-ray, and bacilli in the sputum demonstrated by a positive acid-fast smear.

The optimum duaration of treatment is not known. It probably varies from patient to patient depending on immunologic status, the size of the bacillary population, drug susceptibility of the organisms, the number and kinds of drugs used, and patient adherence to the prescribed regimen. From previous experience, we can predict a high degree of success when patients take two or more effective drugs for 18 months.

Recent studies indicate that with isoniazid and rifampin initial therapy may be shortened to a total duration of 12 months beyond the date of sputum conversion. Successful treatment has been accomplished in as little as six to nine months, but these regimens are still being assessed.(1)

(1) Laurance S. Farer, M.D., M.P.H., "The Modern Approach to Tuberculosis Management", The Journal of Respiratory Diseases, Jan. 1980.

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MONTANA MORBIDITY REPORT

PHSB 3010-201 PUB. No. 307830 Vol: 4:6 Month of: SEPTEMBER 1980

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OCTOBER 1980

	Aseptic Meningitis	Chickenpox	Encephalitis tot.	Giardia	Gonorrhea	Hepatitis Infectious	Hepatitis Serum	Influenza	Measles	Meningococcal Disease	Mumps	Pertussis	Rabies in Animals	Rubella	Salmonella	Shigella	Strep Infection	Tuberculosis
Beaverhead		1															12	
Big Horn		13															17	1
Blaine																	37	
Broadwater																		
Carbon				3														
Carter																		
Cascade		15					1	150							1		37	
Choteau								45							1			
Custer																		
Daniels																		
Dawson		52											1				3	
Deer Lodge								62									11	
Fallon																		
Fergus																		
Flathead																		
Gallatin											1						49	
Garfield		1															1	
Glacier																		
Golden Valley																		
Granite															9		25	
Hill																		
Jefferson																		
Judith Basin								6							1		28	
Lake		1		2											2		2	
Lewis & Clark				1													2	
Liberty																		
Lincoln																		
McCone																		
Madison																		
Meagher																		
Mineral																1		
Missoula		2		2			1	14					1		1	1	4	
Musselshell																		
Park																		
Petroleum																		
Phillips																		
Pondera								12									8	
Powder River																		
Powell																		
Prairie																		
Ravalli				1		1					1						5	
Richland																		
Roosevelt						1									1			
Rosebud		3															12	
Sanders																		
Sheridan													1					
Silver Bow		2						11									87	
Stillwater																		
Sweet Grass		7															7	
Teton																		
Toole																		
Treasure																		
Valley													3				3	
Wheatland																		
Wibaux																		
Yellowstone											1				2			
TOTAL THIS MONTH 1980	-	97	-	9	Not Avail.	2	2	300	-	-	3	-	6	-	18	2	350	1
1979	-	64	-	4	200	20	-	125	1	1	-	-	-	1	9	2	295	3
1978	1	12	-	NA	213	2	-	70	-	-	-	-	7	-	3	5	252	2
REPORTED TO DATE 1980	12	1100	10	124	1041	127	17	4886	2	3	58	3	53	45	154	28	3822	30
1979	30	975	6	58	1740	142	14	1960	56	11	10	13	8	66	66	113	3275	33
1978	28	724	9	NA	1876	204	28	3060	106	4	145	11	19	18	34	112	3199	49

Other Reportable Diseases: 2 Bact. Meningitis - 1 Lake, 1 Rosebud; 1 Hepatitis, Unspec. - Gallatin; 1 Legionnaire's Disease - Gallatin; 7 Mononucleosis; 3 Syphilis.

Delayed Reports: 2 Aseptic Meningitis - 1 Beaverhead, 1 Silver Bow; 4 Encephalitis - 3 Cascade, 1 Yellowstone; 3 Giardia - Missoula; 2 Hepatitis A - 1 Cascade, 1 Lewis & Clark; 1 Hepatitis B - Missoula; 3 Tuberculosis - 1 Blaine, 1 Granite, 1 Phillips; 2 Tularemia - Big Horn. DELETE: 1 Salmonella - Missoula; 1 TB - Jefferson.

Toxic Shock Syndrome

Preventive Health Services Bureau is cooperating with the Center for Disease Control in collecting data for further study of Toxic Shock Syndrome. We welcome reports from public and private health care providers of cases in which signs and symptoms are consistent with TSS. Data for four cases reported by Montana physicians has already been forwarded to CDC.

To assist in your decision of whether or not a case should be reported, the September 19, 1980 MMWR Toxic Shock Syndrome case definition is reproduced below:

1. Fever (temperature >38.9 C [102 F]).
2. Rash (diffuse macular erythroderme).
3. Desquemation, 1-2 weeks after onset of illness, particularly of palms and soles.
4. Hypotension (systolic blood pressure <90 mm Hg. for adults or <5th percentile by age for children <16 years of age, or orthostetic syncope).
5. Involvement of 3 or more of the following organ systems:
   - A. Gastrointestinal (vomiting or diarrhea at onset of illness).
   - B. Muscular (severe myalgia or creatine phosphokinase level >2 x ULN*).
   - C. Mucous membrane (vaginal, oropharyngeal, or conjunctival hyperemia).
   - D. Renal (BUN† or Cr‡ >2 x ULN or >5 white blood cells per high-power field—in the absence of a urinary tract infection).
   - E. Hepatic (total bilirubin, SGOT§, or SGPT¶ >2 x ULN).
   - F. Hematologic (platelets <100,000/mm³).
   - G. Central nervous system (disorientation or alterations in consciousness without focal neurologic signs when fever and hypotension are absent).
6. Negative results on the following tests, if obtained:
   - A. Blood, throat, or cerebrospinal fluid cultures.
   - B. Serologic tests for Rocky Mountain spotted fever, leptospirosis, or measles.

*Twice upper limits of normal for laboratory.
†Blood urea nitrogen level.
‡Creatinine level.
§Serum glutamic oxaloacetic transaminase level.
¶Serum glutamic pyruvic transaminase level.

Rapid assimilation of case data, in numbers great enough to increase reliability of conclusions, is essential. CDC has resources for descriptive investigation, and the potential for gathering case histories nationwide. If you wish to report a case, please phone Judith Gedrose, R.N., M.N., at 449-2645.

Plague

Following the confirmed diagnosis of a human plague case in Montana this summer and, recently, a suspected case reported, our consciousness has been reawakened. The confirmed case was probably not contracted in this state, but Yersinia pestis is known to have infected some animal populations within Montana.

From our experience with these two situations, we would like to reiterate two points. First, human plague could occur in Montana, and a CDC researcher feels it likely we will eventually have such a case. Secondly, prompt reporting and involvement of the state offices (especially the laboratory) is essential. The state offices should be contacted at the first indication that a patient may have a life-threatening communicable disease.

Personnel Changes

Dr. Martin D. Skinner has resigned as Chief of the Preventive Health Services Bureau and State Epidemiologist to accept the position of Director of Disease Control, Division of Health and Medical Services of the Wyoming Department of Health and Social Services.

Dr. John S. Anderson will be our new Bureau Chief. Judith Gedrose, R.N., M.N., has been appointed acting State Epidemiologist. Our best wishes to all of them in meeting the challenges and responsibilites of their new positions.

Mailing List: If you know of anyone who would like to receive this publication, write or call us to place their name on our mailing list. Also, if you feel it is of no value to you, or if your office is getting duplicates, notify us, and we'll stop sending it.

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MONTANA MORBIDITY REPORT

PHSB 3010-201 Vol: 4:7 Month of: OCTOBER 1980

MONTANA MORBIDITY REPORT Published monthly by the Preventive Health Services Bureau of the Department of Health and Environmental Sciences, Cogswell Building, Helena, Montana 59601. Distributed FREE to physicians, public health nurses, sanitarians, hospital administrators

NOVEMBER 1980

*Now being reported by epidemics only.

	Aseptic Meningitis	Chickenpox	Encephalitis - tot	Giardia	Gonorrhea	Hepatitis Infectious	Hepatitis Serum	Influenza	Measles	Meningococcal Disease	Mumps	Pertussis	Rabies in Animals	Rubella	Salmonella	Shigella	Strep Infections	Tuberculosis
Beaverhead																		
Big Horn					6	4												
Plaine					1													
Broadwater																		
Carbon				2														
Carter																		
Cascade					17						1							
Choteau					2													
Custer																		
Daniels													1					
Dawson																		
Deer Lodge					1	1												
Fallon																		
Fergus					2													
Flathead					10													
Gallatin	1			12	10													
Garfield																		
Glacier					6										1			
Golden Valley																		
Granite																		
Hill					1													
Jefferson																		
Judith Basin																		
Lake					1													
Lewis & Clark				1	3													
Liberty																		
Lincoln																		
McCone																		
Madison					1													
Meagher																		
Mineral					1													
Missoula				4	24	1					1				1			
Musselshell																		
Park					1										1			
Petroleum																		
Phillips													1					
Pondera					1	1												
Powder River																		
Powell					2													
Prairie																		
Ravalli					4	1										2		
Richland					2													
Roosevelt				1	3													
Rosebud					5													
Sanders																		
Sheridan					1								1					
Silver Bow					2													
Stillwater																		
Sweet Grass																		
Teton																		
Toole																		
Treasure																		
Valley																		
Wheatland																		
Wibaux																		
Yellowstone					15										1			
TOTAL THIS MONTH	1	*	-	20	122	8	-	*	-	-	2	-	3	-	4	2	*	-
1980																		
1979	1	84	2	2	156	15	3	250	-	2	3	-	1	-	4	18	609	4
1978	2	44	-	NA	165	7	-	115	-	1	1	-	-	-	5	8	372	-
REPORTED TO DATE																		
1980	14	*	10	148	1378	138	17	*	2	3	60	3	56	45	161	30	*	32
1979	32	1059	8	60	1896	159	19	2210	56	13	13	13	8	66	70	131	3884	37
1978	30	700	9	NA	2063	217	28	3175	106	5	147	11	19	18	36	118	3571	56

Other Reportable Diseases: 3 Bacterial Meningitis - 1 Big Horn, 2 Missoula; 1 Hepatitis Non-A, Non-B - Big Horn; 1 Syphilis - Cascade. DELETE 3 Syphilis reported in October.

Delayed Reports: 1 Aseptic Meningitis - Lewis & Clark; 4 Giardia - 1 Lake, 3 Missoula; 3 Hepatitis A - 2 Big Horn, 1 Cascade; 3 Salmonella - Cascade; 2 Tuberculosis - 1 Big Horn, 1 Wheatland; 2 Toxic Shock Syndrome - 1 Cascade, 1 Flathead; 215 Gonorrhea.

TUBERCULOSIS IN NURSING HOMES

The September 26, 1980 issue of "MMWR - Morbidity and Mortality Weekly Report", published by the Center for Disease Control, Atlanta, Georgia, contains an article entitled "Tuberculosis in a Nursing Home - Oklahoma". The Editorial Note is reproduced below:

> **Editorial Note:** This investigation illustrates the potential for transmission of tuberculosis among institutionalized persons such as those in prisons (*1*) or nursing homes. Most nursing home patients are in the older age groups—groups with high rates of tuberculosis infection and disease—and they often have other chronic diseases that may mask the symptoms of tuberculosis. Furthermore, complicating medical conditions may contribute to skin-test anergy in this group.
>
> Because of problems in administering skin tests to older patients and in interpreting the results, screening for tuberculosis in nursing homes should consist of both a chest X ray and a 2-step tuberculin skin test on admission (*2*). Patients whose tests are positive and/or whose X rays are consistent with tuberculosis should be thoroughly evaluated to exclude current disease. INH preventive therapy should be given according to published recommendations (*3*).
>
> Patients with positive skin tests and negative chest X rays who have not completed a course of preventive therapy should be carefully monitored for symptoms suggesting tuberculosis; periodic chest X rays are not recommended. Repeat skin testing of patients whose skin tests have been negative is not recommended unless they are exposed to a case of infectious tuberculosis.
>
> Screening of employees should consist of 2-step skin testing when they are hired and appropriate follow-up and treatment of those who are tuberculin positive. The advisability of retesting each year depends on the prevalence of tuberculosis in the community and the likelihood of exposure to tuberculosis in the nursing home; employees who have been tuberculin negative should be retested if exposed to a case of infectious tuberculosis.
>
> *References*
>
> 1. Stead WW. Undetected tuberculosis in prison, source of infection for community at large. JAMA 1978;240:2544-7.
> 2. Thompson NJ, Glassroth JL, Snider DE, Farer LS. The booster phenomenon in serial tuberculin testing. Am Rev Respir Dis 1979;119:587-97.
> 3. American Thoracic Society, American Lung Association, and Center for Disease Control. Preventive therapy of tuberculous infection. Am Rev Respir Dis 1974;110:371-4.

The arrival of the article was coincidental with several similar situations in Montana. Two nursing homes in the state experienced higher than expected rates of positive reactions when residents were tested with tuberculin skin test antigen. Older adults seem to be a major continuing reservoir for tuberculosis infection in Montana. This is true for the following reasons:

1. The person may have been treated before chemotherapy. Therefore, the bacilli were never eliminated from the person's body, only encapsulated.

2. The person was more likely to have been exposed to M. Tuberculosis organisms when the incidence rate was higher. The dormant organisms can become active when general resistance is lowered by age and/or general health problems.

The recommendations reproduced above, if adopted in nursing homes throughout the state, could possibly move Montana very near to eradication of tuberculosis disease.

DISEASE REPORTING PACKET

The packet containing new information and materials for reporting communicable diseases has been delayed because the printers have been deluged with orders, but we have part of the material, and hope to have the rest of it in time to get it all out to you in the very near future.

FROM ALL OF US TO ALL OF YOU

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MONTANA MORBIDITY REPORT

PHSB 3010-201 Pub. No. 397830 Vol: 4:8 Month of: NOVEMBER 1980

MONTANA MORBIDITY REPORT Published monthly by the Preventive Health Services Bureau of the Department of Health and Environmental Sciences, Cogswell Building Helena Montana 59601 Distributed FREE to physicians, public health nurses, sanitarians, hospital administrators

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		ASEPTIC MENINGITIS	ENCEPHALITIS	GIARDIA	HEPATITIS A	HEPATITIS B	MEASLES	MENING. DISEASE	MUMPS	PERTUSSIS	RABIES, ANIMALS	RUBELLA	SALMONELLA	SHIGELLA	TUBERCULOSIS	GONORRHEA
DISTRICT 1	Daniels															
	Phillips															2
	Roosevelt															5
	Sheridan															
	Valley															3
DISTRICT 2	Dawson												1			
	Garfield															
	McCone															
	Prairie															
	Richland															
	Wibaux															
DISTRICT 3	Carter															
	Custer															
	Fallon															
	Powder River															
	Rosebud													1		3
	Treasure															
DIST. 4	Blaine															1
	Hill															2
	Liberty															
DISTRICT 5	Cascade	1														12
	Chouteau															
	Glacier			1												7
	Pondera															1
	Teton															
	Toole															
DISTRICT 6	Fergus															2
	Golden Valley															
	Judith Basin															
	Musselshell			1												
	Petroleum															
	Wheatland															1
DISTRICT 7	Big Horn				1											5
	Carbon			5												1
	Stillwater															
	Sweet Grass															
	Yellowstone			1	1								2			29
DIST. 8	Broadwater															
	Jefferson															1
	Lewis & Clark			1												9
DIST. 9	Gallatin	1														5
	Meagher															
	Park															
DISTRICT 10	Flathead			1												7
	Lake												1	1		3
	Lincoln															1
	Sanders															
DIST. 11	Mineral															
	Missoula	1		6												20
	Ravalli															1
DISTRICT 12	Beaverhead															1
	Deer Lodge															
	Granite															
	Madison															
	Powell															1
	Silver Bow														1	2
MONTHLY TOTAL	19 80	3	-	16	2	-	-	-	-	-	-	-	4	2	1	125
	19 79	2	-	1	4	4	-	3	1	1	-	(-3)	1	19	3	178
	19 78	2	-	NA	23	1	2	1	1	1	-	4	6	8	5	179
TOTAL TO DATE	19 80	17	10	164	143	18	2	5	61	3	58	45	166	32	33	1508
	19 79	34	9	61	164	22	56	16	-	14	8	68	75	144	40	2086
	19 78	32	9	-	242	28	108	7	-	12	19	22	43	128	65	2268

DELAYED REPORTS:

OTHER DISEASES:

3 Syphillis - 1 Powell; 2 Cascade
1 Lymphogranuloma Venereum - Missoula

PENICILLINASE PRODUCING NEISSIERIA GONORRHOEAE (PPNG)

The Montana Venereal Disease Program has reported their second case of PPNG. Our only defense is early detection and rapid treatment. It is recommended that all suspects, contacts, and diagnosed cases of PPNG be treated with 2 gms. spectinomycin I.M. All cases of gonorrhea must be reported to the health department for follow-up. These cases must be interviewed and encouraged to refer their sex contacts in for examination. A very important factor with PPNG is the test of cure from 3 to 7 days after therapy. This test should help us to identify PPNG at a much earlier date than now possible. A rescreen culture 4 - 7 weeks after therapy also is advised.

SYPHILIS IN GREAT FALLS

An outbreak of syphilis in the Great Falls area has resulted in intensified control efforts by the Cascade County Health Department and the State Department of Health and Environmental Sciences, according to Dave Bean, State Venereal Disease Control Program Coordinator.

"We have confirmed nine cases of syphilis in persons aged 14 through 40 years in the past two months in Great Falls", Bean said, "and ordinarily we would expect only 12 to 14 cases from throughout Montana within a year. We also have reports from six other states of cases in those states which indicate a history of recent travel through Great Falls."

Special control efforts include working with Great Falls area laboratories which handle syphilis testing and alerting private physicians to the presence of the disease.

PNEUMOCCOCAL VACCINE

Merck, Sharp and Dohme (MSD) has notified health departments of a change in the recommendation for revaccination with PENUMOVAX ® (Pneumococcal Vaccine, Polyvalent, MSD). The recommended revaccination interval is now not less than 5 years.

The previous recommendation for revaccination was every 3 years. According to the MSD report recent studies have shown that antibody levels persist over periods of 42 months. The report also mentions that the available data suggests that revaccination before 5 years results in more frequent and more severe local reactions, especially in persons who have retained high antibody levels.

A HIGH RISK GROUP STUDY

The Lane County Medical Society & Health Division of Oregon undertook a project worthy of note. Since pneumoccocal vaccine is recommended for asplenic patients, the two organizations did an awareness survery of known asplenic persons in the county. Along with a questionnaire sent to the persons was an information packet. It informed the patients of increased risk of any type of infection.

The questionnaire returned by 56% of the identified asplenic persons in the county yielded the following information: 1) 51% did not know they were at increased risk of infection; 2) 56% had not received Pneumovax; 3) during a 3 year period, 2 deaths and 2 residual deafness cases occurred in 134 asplenic persons who developed bacteremia.

Recommendations resulting from the study include:

1. Similar information programs be instituted for all splenectomy patients
2. Seeking immediate medical care in response to any signs of infection should be stressed to asplenic persons
3. Pneumococcal vaccine should be a standard of care for asplenia[1]

[1] "Splenectomy and Sepsis: Lane County Prevention Program", Oregon Communicable Disease Summary, Volume 29, No. 51, December 20, 1980

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